Program HH Authorization Dental Criteria

Orthodontic Treatment (limited to children thru age 20)

(If client is covered under Medicaid (MA) prior authorization must go through MA)

At least one of the following criteria must be met:

- There is disfigurement of the patient's facial appearance including protrusion of upper or lower jaws or teeth
- There is spacing between adjacent teeth which interferes with the biting function
- There is an overbite to the extent that the lower anterior teeth impinge on the roof of the moth when the person bites
- Positioning of jaws or teeth impairs chewing or biting function
- Based on a comparable assessment of the above criteria, there is an overall problem that interferes with the biting function

The dentist must submit the following documentation when considering orthodontic care:

• Description of classification of occlusion (e.g., angle class, arch crowding or spacing, etc.)

• Functional problems (e.g., overbite, overjet, cross bites, etc.)

• Disfiguring characteristics (e.g., facial asymmetry, etc.)

• Contributing factors (e.g., missing teeth, impacted teeth, etc.)

• Specific treatment plan and appliances (enter the appropriate procedure code)

• Five intraoral photographs; upper and lower occlusal. Prints or mounted slides are acceptable. Include profile photos

• Appropriate radiographs (panorex or full mouth and cephalometric)

A separate letter may be included with additional information if desired. If the above information is not adequate, DHS may request study models. **Do not send models unless requested.**

Periodontal Scaling and Root Planing

Periodontal scaling and root planing criteria must be documented in the recipient's record to be eligible for reimbursement:

• Evidence of bone loss must be present on the current radiographs - panoramic, full mouth series or bitewing - to support the diagnosis of periodontitis

• There must be current periodontal charting with six point and mobility noted, including presence of pathology and periodontal prognosis

• The pocket depths must be greater than four millimeters

• Classification of the periodontology case type must be in accordance with documentation established by the American Academy of Periodontology

For periodontal maintenance, criteria include:

• Date of original periodontal scaling and root planning

• Documentation showing response to treatment/benefit from treatment (e.g., initial and current periodontal charting)

• Current radiographs

Claims processed for any combination of D1110 adult prophylaxis, D4355 full mouth debridement, or D4341 periodontal scaling and root planing (4 or more teeth per quadrant) or D4342 (1 to 3 teeth per quadrant) on the same date will deny. Multiple quadrants for D4341 (4 or more teeth per quadrant) and D4342 (1 to 3 teeth per quadrant) same day are allowed.

Removable Partial Dentures

• The crown to root ratio must at least 1:1

• The surrounding abutment teeth and remaining teeth must not have extensive tooth decay

• The abutment teeth must not have large restorations or stainless steel crowns (metal framework partials only)

Requests for authorization for partial dentures, interim or permanent must be submitted with the following dental history, case information, and documentation:

- History regarding all previous prostheses
- Dental history pertinent to request
- Periapical of the involve arch for all partial denture requests
- Indicate on the ADA claim form all missing teeth and teeth to be replaced by the partial denture ("x" for all missing teeth and "o" for teeth to be replaced by partial)
- Periodontal charting and periodontal prognosis of remaining teeth when requesting metal framework partial dentures

If requesting replacement of existing prosthesis:

- Specific reason for request
- Specify why existing partial denture can not be relined, rebased, or repaired

Fixed Partial Denture – Pontics and Crowns (for children thru age 20)

Authorization is required for fixed dentures (that are cost-effective) for persons who are unable to use removable dentures because of their medical condition. Replacement of damaged fixed dentures for individuals who are unable to use removable dentures due to medical condition also require authorization.

Requests for authorization for fixed denture must be submitted with the following documentation:

- The recipient's mental/physical condition including ICD-9-CM diagnoses that cause the recipient's inability to use a removable denture
- An explanation of the reason the recipient is unable to use a removable denture
- Radiographs of the recipient's current dental condition of the remaining dentition
- Current periodontal charting
- The specific treatment plan and the long-range prognosis for the remaining dentition

Molar Root Canal

- Tooth must have a good long term prognosis
- Tooth must have adequate remaining tooth structure to be restored without a cast crown
- Tooth must not have a single pocket depth of seven or greater
- Tooth must have minimal mobility

If criteria are not specified by Program HH the criteria for Medial Assistance (MA) will be applied.

Program HH does not cover treatment deemed to be cosmetic or for aesthetic reasons.

A service is medically necessary if: (a) it is reasonably calculated to prevent, diagnose, or treat conditions in the client that endanger life, cause pain, or cause functionally significant deformity or malfunction and (b) there is no other equally effective course of treatment available or suitable for the client requesting the service which is more conservative or substantially less costly and (c) services shall be of a quality that meets professionally recognized standards of health care and *must be substantiated by records including evidence of such medical necessity and quality. Those records shall be made available to the Department upon request.